16 Sever Street • Charlestown, MA 02129-1305
Local phone: 617-241-9220 • In MA: 800-442-9939 • Outside MA: 800-225-6135
Fax: 617-241-8168 • Website: http://www.teamstercare.com

POSSIBLE THIRD PARTY CLAIM
REQUEST FOR ADDITIONAL INFORMATION

Please advise if you have any type of third party claim filed regarding the incident listed on the weekly disability claim you submitted.

PLEASE COMPLETE AND RETURN TO TEAMSTERSCARE MEMBER SERVICES

Member Name

Last Four Digits of Social Security No. **Date of Incident:**

1. Do you have a workers' compensation (WC) claim, a motor vehicle claim, a lawsuit or any type of insurance claim filed regarding this incident?

Yes ☐ **WC Claim ___ Insurance Claim ___ Lawsuit ___ No** ☐

If yes, list the insurance company involved:

Insurance Company Name & Address

Insurance Company Adjustor and Phone Number **Claim No.**

If you have retained an attorney, please list your attorney information:

Name, Address & Phone No. of Attorney:

2. Have you received any workers' compensation payments regarding this incident?

Yes ☐ **No** ☐

If yes, list starting date of workers' compensation payments:

List ending date of workers' compensation payment:

Member Signature **Date Signed**